UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

YOLANDA BEJASA-OMEGA,

Plaintiff,

-*v*.-

PV HOLDING CORP. and RONALD M. SKLON,

Defendants.

----------X

Docket No.: 07 Civ. 2950 (SWK)
Justice: Hon. Shirley Wohl Kram

PLAINTIFF'S RULE 26 DISCLOSURE

Plaintiff, by her counsel, make the following disclosure pursuant to FRCP Rule 26(a)(1):

(A) Names and addresses of persons having discoverable information:

All persons listed on the police accident report (including the reporting police officer).

(B) Documents and things in the possession of the disclosing party:

Authorizations for records from medical providers annexed. Said authorizations include: Dr. Nirmal Tejwani; NYU Hospital for Joint Diseases; Bellevue Hospital; North Shore University Hospital at Forest Hills; Dr. Jhiansi Rao.

Police accident report annexed.

(C) Computation of damages:

Authorization for records from GEICO, the no-fault insurance carrier annexed.

Authorization for records from Empire Blue Cross Blue Shield annexed.

(D) Insurance agreement:

Not applicable.

Dated: New York, New York
June 6, 2007

SAKKAS & CAHN, LLP

By: _____

MATTHEW SAKKAS, ESQ. (WMS 3351)
Attorney for Plaintiff
150 Broadway, Suite 1307
New York, N.Y. 10038
Tel: (212)693-1313
Fax: (212)693-1314

POLICE ACCIDENT REPORT (NYC)

MV-104AN (5/04)

Precinct: 017 | Accident No.: 3056 | Complaint Number: | ☐ AMENDED REPORT

Accident Date (Month / Day / Year)	Day of Week	Military Time	No. of Vehicles	No. Injured	No. Killed	Not Investigated at Scene ☐ / Reconstructed ☐	Left Scene ☐	Police Photos ☐ Yes ☐ No
10 / 27 / 2006	FRI	0830	01	01	0			

VEHICLE 1	☐ VEHICLE 2	☐ BICYCLIST	☒ PEDESTRIAN	☐ OTHER PEDESTRIAN

	VEHICLE 1	VEHICLE 2
Driver License ID Number / State of Lic.	S450 733 50 030 0 / FL	
Driver Name - exactly as printed on license	RONALD M SKLON	BEJASA-OMEGA, YOLANDA
Address (Include Number & Street) / Apt. No.	1900 CARYLE LN	60-32 BOOTH ST
City or Town / State / Zip Code	THE VILLAGES / FL / 32162	ELMHURST / NY / 11373
Date of Birth (Month / Day / Year) / Sex / Unlicensed / No. of Occupants / Public Property Damaged	01 / 30 / 50 / M / ☐ / 01 / ☐	12 / 2 / 47 / F / ☐ / / ☐
Name–exactly as printed on registration / Sex / Date of Birth	PV HOLDING CORP	PEDESTRIAN
Address (Include Number & Street) / Apt. No. / Haz. Mat Code / Released	300 CENTRE POINTE DR / / / ☐	/ / / ☐
City or Town / State / Zip Code	VIRGINIA BEACH / VA	
Plate Number / State of Reg. / Vehicle Year & Make / Vehicle Type / Ins. Code	986UNS / CT / 07 CHEVR / 4DSD. / 999	
Ticket/Arrest Number(s)	N/A	N/A
Violation Section(s)		

VEHICLE 1

Check if involved vehicle is:
☐ more than 95 inches wide;
☐ more than 34 feet long;
☐ operated with an overweight permit;
☐ operated with an overdimension permit.

VEHICLE 1 DAMAGE CODES

	1	2
Box 1 - Point of Impact / Box 2 - Most Damage	3	18
Enter up to three more Damage Codes	3	4	5

Vehicle Towed: By / To: NO TOW.

VEHICLE 2

Check if involved vehicle is:
☐ more than 95 inches wide;
☐ more than 34 feet long;
☐ operated with an overweight permit;
☐ operated with an overdimension permit.

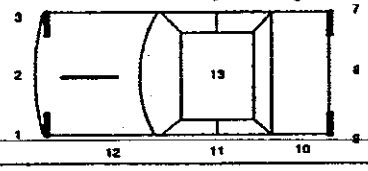
VEHICLE 2 DAMAGE CODES

	1	2
Box 1 - Point of Impact / Box 2 - Most Damage		
Enter up to three more Damage Codes	3	4	5

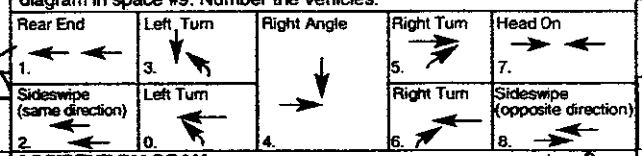
Vehicle Towed: By / To:

VEHICLE DAMAGE CODING:

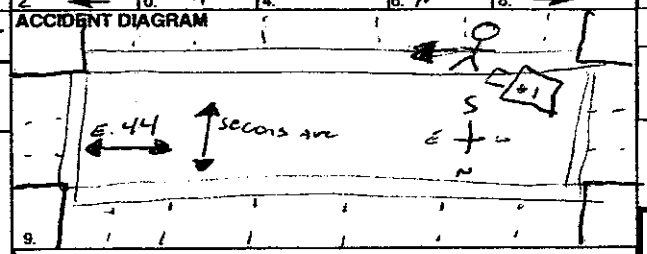
1-13. SEE DIAGRAM ON RIGHT.
14. UNDERCARRIAGE
15. TRAILER
16. OVERTURNED
17. DEMOLISHED
18. NO DAMAGE
19. OTHER



Circle the diagram below that describes the accident, or draw your own diagram in space #9. Number the vehicles.



ACCIDENT DIAGRAM



Cost of repairs to any one vehicle will be more than $1000.
☐ Unknown/Unable to Determine ☐ Yes ☒ No

Reference Marker	Coordinates (if available)
	Latitude/Northing:
	Longitude/Easting:

Place Where Accident Occurred: ☐ BRONX ☐ KINGS ☒ NEW YORK ☐ QUEENS ☐ RICHMOND

Road on which accident occurred E. 44 ST (Route Number or Street Name)

at 1) intersecting street SECOND AVE (Route Number or Street Name)

or 2) ____ ____ ☐N ☐S ☐E ☐W of ____ (Feet / Miles) (Milepost, Nearest Intersecting Route Number or Street Name)

Accident Description/Officer's Notes: PED STATED SHE WAS CROSSING SECOND AVE ON THE SOUTH SIDE OF E.44 FROM WEST TO EAST WITH WALK SIGN, WHEN VEH #1 ATTEMPTING TO TURN SOUTH ONTO SECOND FROM E/B E.44 STRUCK HER. PED WAS IN CROSS WALK WITH WALK SIGN. VEH #1 DRIVER AGREES TO ABOVE STORY - STATED LIGHT TURNED GREEN & HE ATTEMPT TO TURN RIGHT. PO DID NOT WITNESS

	8	9	10	11	12	13	14	15	16	17	BY	TO	18	Names of all involved	Date of Death Only
A	1	1	4	1	56	M	/	/	/	/		/		RONALD SKLON	
B	P	8	1	/	58	F	11	10	6	1659		7202		BEJASA-OMEGA, YOLANDA	
C															
D															
E															
F															

ALL INVOLVED

Officer's Rank and Signature	Tax ID No.	NCIC No.	Precinct	Post/Sector	Reviewing Officer	Date/Time Reviewed
D. Mk	932959	03030	017		PO	10/27/06

Print Name in Full: MARKOWSKI

Address	Address
Date of Birth: Month / Day / Year — Telephone (Area Code) ( )	Date of Birth: Month / Day / Year — Telephone (Area Code) ( )
B Last Name BEJASA-OMEGA First YOLANDA M.I.	E Last Name First M.I.
Address 60-32 80TH ST ELMHURST NY 11373	Address
Date of Birth: Month 12 / Day 2 / Year 47 — Telephone (Area Code) ( )	Date of Birth: Month / Day / Year — Telephone (Area Code) ( )
C Last Name First M.I.	Highway Dist. at Scene? ☐ Yes ☒ No Name:
Address	
Date of Birth: Month / Day / Year — Telephone (Area Code) ( )	Shield No.

ENTER INSURANCE POLICY NUMBER FROM INSURANCE IDENTIFICATION CARD, EXPIRATION DATE (IN ALL CASES), AND VIN.

Vehicle No. 1 SELF — Vehicle No.2 _____

Expiration Date INSURES — Expiration Date _____

VIN 1G12T58N37F109466 — VIN _____

WITNESS (Attach separate sheet, if necessary)

Name	Address	Phone
SONIA BEHAROVIC	121-45 6TH AVE College Pt NY 11356	(917) 621 7642

DUPLICATE COPY REQUIRED FOR:

- ☒ Dept. of Motor Vehicles (if anyone is killed/injured)
- ☐ Motor Transport Division (P.D. vehicle involved)
- ☐ NYC Taxi & Limousine Comm. (if a Licensed taxi or limousine involved)
- ☐ Other City Agency (Specify) _____
- ☐ Office of Comptroller (if a City vehicle involved)
- ☐ Personnel Safety Unit (if a P.D. vehicle involved)
- ☐ Highway Unit _____

NOTIFICATIONS: (Enter name, address, and relationship of friend or relative notified. If aided person is unidentified, list Missing Person Squad member who was notified. In either case, give date and time of notification.)

PROPERTY DAMAGED (other than vehicles)	**OWNER OF PROPERTY** (include city agency, where applicable)

IF NYPD VEHICLE IS INVOLVED:

Police Vehicle–Operator's First Name	Last Name	Rank	Shield No.	Tax ID. No.	Command

Make of Vehicle	Year	Type of Vehicle	Plate No.	Dept. Vehicle No.	Assigned To What Command

Equipment in Use At Time of Accident

☐ Siren ☐ Horn ☐ Turret Light ☐ 4-Way Flasher ☐ High-Level Warning Lights ☐ Traffic Cones ☐ Headlights

ACTIONS OF POLICE VEHICLE

- ☐ Responding to Code Signal _____
- ☐ Pursuing Violator
- ☐ Other (Describe) _____
- ☐ Complying with Station House Directive
- ☐ Routine Patrol

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address: **60-32 Booth Street, Elmhurst, NY 11373**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jirmal Tejwani, MD, HJD 301 East 17th St, New York, N.Y.

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healy McGuire & Salley, 1140 Frankin Ave., Garden City, NY 11530

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form: **Matthew Sakkas, Esq.**	13. Authority to sign on behalf of patient: **Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH CARE DECISIONS. YOU MAY EXECUTE A HEALTH CARE PROXY TO DO THIS.

This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address: **60-32 Booth Street, Elmhurst, NY 11373**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Hospital For Joint Diseases, 301 East 17th Street, NY, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healy McGuire & Salley, 1140 Frankin Ave., Garden City, NY 11530

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of ~~patient or representative~~ authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

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TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 20[illegible]

OCA Official Form No.: 960

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[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address: **60-32 Booth Street, Elmhurst, NY 11373**		

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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
North Shore University Hospital, 102-01 66th Rad, Forest Hills, N.Y. 11375

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healy McGuire & Salley, 1140 Frankin Ave., Garden City, NY 11530

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

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_____ Date: 5/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 20[illegible]

OCA Official Form No.: 960

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Bellevue Hospital, 27th Street and First Ave, NY, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healy McGuire & Salley, 1140 Frankin Ave., Garden City, NY 11530

9(a). Specific information to be released:

- ☑ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/30/07
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH CARE DECISIONS. YOU MAY EXECUTE A HEALTH CARE PROXY TO DO THIS.

This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jhiansi Rao, M.D., 59 25 Kissena Blvd Flushing, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healy McGuire & Salley, 1140 Franklin Ave., Garden City, NY 11530

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

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THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address: **60-32 Booth Street, Elmhurst, NY 11373**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
GEICO 750 Woodbury Road, Woodbury NY 11797

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healy McGuire & Salley, 1140 Franklin Ave., Garden City, NY 11530

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: **No Fault File No: 001472636-0101-111**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

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TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

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Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address: **60-32 Booth Street, Elmhurst, NY 11373**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Empire Blue Cross Blue Shield, PO Box 1407 Church Street Station, New York, N.Y. 10008

8. Name and address of person(s) or category of person to whom this information will be sent:
Monfort Healey McGuire & Salley, 1140 Franklin Ave., Garden City, NY 11530

9(a). Specific information to be released:

- ☑ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **Claim No. 63189227070**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/30/07
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

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Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 18, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jirmal Tejwani, MD Hospital For Joint Diseases, 301 East 17th Street, New York, N.Y.

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, PC., 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

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Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Hospital For Joint Diseases, 301 East 17th Street, New York, N.Y.

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, PC., 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of ~~patient or representative~~ authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH CARE DECISIONS. YOU MAY EXECUTE A HEALTH CARE PROXY TO DO THIS.

This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Bellevue Hospital, 27th Street and First Ave, NY, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, PC., 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/30/07
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

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This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address: **60-32 Booth Street, Elmhurst, NY 11373**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
North Shore UNiversity Hospital, 102-01 66th Street, Forest Hill, NY 11375

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, PC., 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/20/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH CARE DECISIONS. YOU MAY EXECUTE A HEALTH CARE PROXY TO DO THIS.

This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 12, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
GEICO 750 Woodbury Road, Woodbury NY 11797

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: **No Fault File No: 001472636-0101-111**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

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I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

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TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 21 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 12, 20[illegible]

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jhiansi Rao, M.D., 59 25 Kissena Blvd Flushing, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, PC., 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 5/30/07

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

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THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 21 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Yolanda Bejasa-Omega	**12/2/47**	
Patient Address		
60-32 Booth Street, Elmhurst, NY 11373		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Empire Blue Cross Blue Shield, PO Box 1407 Church Street Station, New York, N.Y. 10008

8. Name and address of person(s) or category of person to whom this information will be sent:
Reardon & Sclafani, 220 White Plains Road, Suite 235, Tarrytown, NY 10591

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: **Claim No. 63189227070**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**2 years**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
Matthew Sakkas, Esq.	**Attorney**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/20/07
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DURABLE POWER OF ATTORNEY TO EXECUTE A WRITTEN REQUEST FOR PATIENT INFORMATION UNDER SECTION 18 OF THE NEW YORK STATE PUBLIC HEALTH LAW

THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH CARE DECISIONS. YOU MAY EXECUTE A HEALTH CARE PROXY TO DO THIS.

This is intended to constitute a **DURABLE POWER OF ATTORNEY** to execute a written request for patient information under Section 18 of the New York State Public Health Law:

I, Yolanda Bejasa-Omega

do hereby appoint my attorney: Sakkas & Cahn, Esqs. located at 150 Broadway Suite 1307, New York, New York 10038 (212) 693-1313

as my attorney-in-fact to execute a written request for patient information under section 18 of the New York State Public Health Law in my name, place and stead in any way which I myself could do, if I were personally present.

THIS DURABLE POWER OF ATTORNEY SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCOMPETENCE.

TO INDUCE ANY THIRD PARTY TO ACT HEREUNDER, I HEREBY AGREE THAT ANY THIRD PARTY RECEIVING A DULY EXECUTED COPY OR FACSIMILE OF THIS INSTRUMENT MAY ACT HEREUNDER, AND THAT REVOCATION OR TERMINATION HEREOF SHALL BE INEFFECTIVE AS TO SUCH THIRD PARTY, AND I FOR MYSELF AND FOR MY HEIRS, EXECUTORS, LEGAL REPRESENTATIVES AND ASSIGNS, HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS ANY SUCH THIRD PARTY FROM AND AGAINST ANY AND ALL CLAIMS THAT MAY ARISE AGAINST SUCH THIRD PARTY BY REASON OF SUCH THIRD PARTY HAVING RELIED ON THE PROVISIONS OF THIS INSTRUMENT.

THIS DURABLE GENERAL POWER OF ATTORNEY MAY BE REVOKED BY ME AT ANY TIME.

Yolanda Bejasa-Omega

In Witness Whereof, I have hereunto signed my name and affixed my seal this 01 day of November, 2006.

NANCY HIGER
Notary Public, State of New York
No. 31-4990774
Qualified in New York County
Commission Expires January 13, 2010

AFFIRMATION OF SERVICE

MATTHEW SAKKAS, an attorney duly admitted to practice law before this Court, affirms to the truth of the following under penalty of perjury:

I am not a party to this action, I am over 18 years of age and I reside in New York, New York. On June 6, 2007 I mailed a copy of the within ***PLAINTIFF'S RULE 26 DISCLOSURE*** to the persons or firms listed below at the following addresses:

Reardon & Sclafani, P.C.
Attorneys for Defendant PV Holding Corp.
Attn.: Michael Sclafani
220 White Plains Road, Suite 235
Tarrytown, NY 10591

Montfort, Healy, McGuire & Salley
Attorneys for Defendant Ronald M. Sklon
Attn.: Hugh Larkin
1140 Franklin Avenue
P.O. Box 7677
Garden City, NY 11530-7677

by enclosing a copy of same in a postpaid properly addressed envelope and depositing said envelope in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State.

Dated: New York, New York
June 6, 2007

S A K K A S & C A H N , L L P

By: _____

MATTHEW SAKKAS, ESQ. (WMS 3351)
Attorney for Plaintiff
150 Broadway, Suite 1307
New York, N.Y. 10038
Tel: (212)693-1313
Fax: (212)693-1314

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Docket No.: 07 Civ. 2950 (SWK)
Justice: Hon. Shirley Wohl Kram

YOLANDA BEJASA-OMEGA,

Plaintiff,

-v.-

PV HOLDING CORP. and RONALD M. SKLON,

Defendants.

PLAINTIFF'S RULE 26 DISCLOSURE

SAKKAS & CAHN, LLP
Attorney for Plaintiff
150 Broadway, Suite 1307
New York, N.Y. 10038
Tel:(212)693-1313
Fax:(212)693-1314